



Health Services
LOS ANGELES COUNTY

September 22, 2011

**Los Angeles County
Board of Supervisors**

Gloria Molina
First District

Mark Ridley-Thomas
Second District

Zev Yaroslavsky
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

TO: Supervisor Michael D. Antonovich, Mayor
Supervisor Gloria Molina
Supervisor Mark Ridley-Thomas
Supervisor Zev Yaroslavsky
Supervisor Don Knabe

FROM: Mitchell H. Katz, M.D.
Director

**SUBJECT: STATUS REPORT ON THE IMPLEMENTATION OF THE
1115 MEDICAID WAIVER**

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

John F. Schunhoff, Ph.D.
Chief Deputy Director

On November 16, 2010, your Board directed the Chief Executive Officer (CEO), the Interim Director of the Department of Health Services (DHS), and the Directors of Mental Health and Public Health to report back to the Board within 30 days and monthly thereafter on a proposed plan to implement the Medicaid Waiver (Waiver). On December 7, 2010, your Board directed the CEO and the Directors of DHS and DMH to work with the Association of Community Human Service Agencies and the Community Clinic Association to report back to the Board within 60 days on a timeline and process to identify program sites to pilot the concept of patient-centered behavioral health care homes. This report is the latest monthly report in response to these motions.

HEALTHY WAY LA – LOW INCOME HEALTH PROGRAM (LIHP)

DHS received notice that it met all program requirements by the July 1, 2011 deadline and DHS implemented its program on July 1, 2011. A contract template was completed by the State and County-specific contracts are expected to be signed by September 30, 2011.

The HWLA-Matched network consists of DHS facilities, Community Partner (CP) clinics, and contracted hospitals. New HWLA agreements with CPs, covering HWLA Matched and Unmatched Services were approved by your Board on June 14, 2011 replacing previous Public Private Partner (PPP) contracts, HWLA contracts and SB 474 contracts. In addition, on September 20, 2011 your Board delegated authority to DHS to execute amendments to existing HWLA-Matched agreements, and to offer new HWLA-Matched agreements, to accommodate the transition of current Ryan White CARE Act program clients to HWLA. DHS is in the process of amending contracts and offering new contracts accordingly.

Prior to the start of the new HWLA program, a total of 62,052 active HWLA members continued into the new program.

The new HWLA program began on July 1 and DHS launched "Operation Full Enrollment," a campaign aimed at ramping up enrollment and purposefully utilizing as many DHS staff as possible in the process. DHS facilities cross-trained more staff to take HWLA applications and to communicate with potentially eligible,

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existing patients, as part of our "in-reach" work. From July 1 through September 19 of this year 70,251 in-reach patient contacts were made, and a total of 11,054 patients who are seen at DHS clinics met eligibility requirements and were enrolled. The monthly enrollment for July and August was over double the monthly average from the previous 12 months. In order to achieve these high enrollment numbers, over 130 non-HWLA enrollment staff assisted in HWLA enrollment in a part-time or full-time capacity.

In addition, over 5,000 individuals were enrolled at Community Partner clinics, and 653 at DMH facilities.

The new HWLA enrollments have more time-consuming enrollment requirements as compared with the previous program requirements. Process improvements are in place and a number of issues have been addressed. For example, backlogs from Community Partners have been reduced and improved functionality of the web-based enrollment application has been implemented. DHS now hosts a weekly conference call with DHS staff, Community Partners, and DMH to share best practices and address impending issues. An updated website (www.ladhs.org/hwla) provides patient and consumer information and regular training schedules and includes YouTube training videos. In addition, we will provide on-site support for Community Partner clinics when needed. Through these combined efforts, submission of completed HWLA applications to DHS from Community Partners has increased, and incomplete applications along with backlogs of completed applications have significantly decreased.

ENROLLMENT OF SPDs IN DHS

In the first four months of SPD enrollment (June 1 through September 1, 2011), the net SPD L.A. Care enrollees assigned to DHS primary care providers is 12,200 (41% of our annual enrollment target of 30,000). The original intent in enrollment planning between DHS and L.A. Care was to enroll SPD patients that have a previously received care from DHS. However, there is a challenge with membership assignment at the State level to meet this original intent. An analysis of June and July data showed that of the assigned SPD patients, only 52% have used a DHS facility and only 12% have visited a DHS primary care provider in the past 18 months. Therefore, many of the new SPD enrollees are not familiar with the DHS system. The new influx of SPD patients to DHS has resulted in a noticeable increase in calls to DHS as the patients were unsure on how to access DHS services or wanted to continue care with their current (non-DHS) primary care provider and/or specialists. In order to improve services for patients, DHS and L.A. Care staff are meeting regularly and working collaboratively to improve our care coordination and care transition processes.

DELIVERY SYSTEM REFORM INCENTIVE POOL (DSRIP)

DHS continues to make progress toward completing milestones for the DSRIP component of the 1115 Waiver. Activities and accomplishments from the first six months of Demonstration Year 7 will be reported in the Spring of 2012. A status update on individual DSRIP milestones is attached.

IMPROVING PRIMARY CARE AND SPECIALIST ACCESS

As we continue to transform our system to meet future health care reform requirements and ultimately provide access to our patients, one immediate measure initiated by the Ambulatory Care Network in partnership with the specialty clinics is to improve specialty care access. For the last two months DHS staff identified patients seen in DHS specialty care and urgent care clinics, as well as DHS Emergency

rooms that did not have a primary care provider. Patients identified in this process are those who no longer need specialty care or who could be more effectively co-managed by both the primary care provider and specialist. In collaboration with our Community Partners, who provided DHS with 15,124 appointment slots, DHS identified and linked approximately 14,000 patients to Community Partners. This linkage process was based on the availability of appointment slots as provided by the Community Partner and the geographic proximity to the patient's home. This effort takes advantage of the primary care resources available through the Community Partners and improves the ability of DHS and our Community Partners to provide effective and cost-efficient patient care services. All affected patients received a letter notifying them of the name of the clinic they had been "assigned" to for their future primary care needs. This process will be repeated on a quarterly basis.

The next status report to your Board is targeted for October 14, 2011. If you have any questions, please contact me or Dr. Alexander Li, Ambulatory Care Chief Executive Officer, at 213-240-8344.

MHK:WS:jp
Attachment

c: Chief Executive Office
Executive Office, Board of Supervisors
County Counsel
Department of Mental Health
Department of Public Health

Project		DSRIP DY 7 Milestones		September 2011 update
		Milestone	Category I	
Implement and Utilize Disease Management Registry Functionality	Disease management registry functionality is available in at least one clinic in each of at least 8 DHS facilities.		Registry vendor contract due to be completed by early October, including the technical modifications statement of work. Initial implementation should start by December.	
	At least 55% of patients with diabetes, heart failure or asthma seen in the clinics with registry access are entered into the registry.		As the registry application is implemented, all empaneled patients (including with diabetes, heart failure, or asthma) within medical homes will be entered into the registry.	
Enhance Urgent Medical Advice	Expand access to NAL by 10% over baseline.		Flyers and refrigerator magnets are now being included in new member packets, which should increase NAL awareness and utilization. Data on NAL usage rates is being collected and will be trended on a quarterly basis.	
	Increase by 10% over baseline the number of NAL patient contacts who reported intent to go to the ED for non-emergent conditions but were redirected to non-ED resources.			
Enhance Coding and Documentation for Quality Data	Implement HIPAA 5010 transaction sets to be able to communicate with institutions that are able to receive and send such transactions.		Harbor-UCLA, the last of the facilities to have 5010 capabilities implemented, will go live by mid-October 2011.	
	Train staff on the changes in work flow (related to HIPAA 5010).		DHS employees require only minimal training on workflow changes related to implementation of HIPAA 5010; this will be provided by our contracted billing and IT vendors in late 2011/early 2012 and documented by Finance staff. More substantial training is required of DHS contracted billing vendors. Medicare billing vendors are currently in 5010 testing. Regarding Medi-Cal billing, the State has not yet released the required 5010 Companion Guide required for 5010 programming and testing. Upon the State's release of the 5010 Companion Guide our billing vendors will commence programming and testing. Once programming and testing is complete, vendors will provide training to appropriate staff mid-December 2011.	
Enhance Performance Improvement and Reporting Capacity	Participate in CHART or other statewide, public hospital or national clinical database for standardized data sharing.		Harbor UCLA, LAC-USC, and Olive View Medical Center report to CHART (California Hospital Assessment and Reporting Taskforce). Rancho reports Functional Independence Measures (FIM) to the Uniform Data System for Medical Rehabilitation.	
	Share quality dashboard or scorecard (including patient satisfaction measures) with organizational leadership on a regular basis; post on DHS public website.		Performance measures are continually reported to senior leadership. DHS public website continues to report quality and patient satisfaction data. We will make refinements to these reporting tools in late 2011/early 2012.	

Project		September 2011 update	
DSRIP DY 7 Milestones		Milestone	
Expand Medical Home		Category II	
Expand Medical Home	Ensure at least 20 primary care providers deliver care using the medical home model.		The ACN's initial empanelment exercise has been completed and staff are currently validating patient lists. Once validation is complete, each of our primary care FTEs will be assigned patient panels. We anticipate that all primary care providers within ACN will be empaneled before December 2011. (116 FTEs and 78,500 patients).
	Assign at least 10,000 patients to provider-led medical home teams.		
Expand Chronic Care Management Model	Determine baseline percentage of patients with diabetes, heart failure or asthma with at least one recorded self-management goal.		Awaiting Registry implementation.
	Implement a comprehensive risk-reduction program for patients with diabetes mellitus that includes glycemic, blood pressure and lipid control in primary care. Target patients include those with Diabetes related inpatient admissions and those with high risk score (HbA1c + LDL + BP).		Care kits addressing risk reduction among patients with diabetes have been developed. Care kit training of all ACN primary care clinic staff is currently underway.
	Expand and document interaction types between patient and health care team beyond one-to-one visits to include group visits, telephone visits, and other interaction types.		Baseline established.
	Determine baseline: Blood pressure control among patients with completed stroke who are empaneled at any primary care medical home with registry access.		Awaiting Registry implementation.
Integrate Physical and Behavioral Health Care	Co-locate mental health services with primary care in 4 LAC DHS directly operated or contract facilities.		Five co-location sites are currently operating (Long Beach, El Monte, Roybal, High Desert, and Humphrey); DMH is recruiting staff for Mid-Valley and planning is underway for MLK and Hudson.
	Track referrals from primary care providers to on-site mental health professionals to be used at the co-location sites.		Preliminary tracking mechanism is in place; it is being further refined in an official Policy and Procedure that is in final stages of development.
	Use joint consultations and treatment planning at co-location sites, and coordinate resources to improve patient education, support, and compliance with the medication regimen.		Joint consultations will be defined as part of the Policy and Procedure document noted above.
	Integrate depression screening to 15% of enrolled patients with diabetes assigned to co-location sites.		New disease management registry to be customized to include ability to track depression screening. Baseline data collection effort not yet initiated. Providers to be educated regarding depression screening as needed as part of the medical home model.
	Ensure at least 70% of initial behavioral health visit appointment waiting times among patients enrolled in DHS medical homes who meet medical necessity criteria are less than 30 business days.		Preliminary data available. Co-located DMH staff are adjusting referral flows in response to high referral volumes at specific co-located clinics in order to achieve mandated access standards for managed care populations.

DSRIP DY 7 Milestones		September 2011 update
Project	Milestone	
Patient/Care Giver Experience	Category III	
	Undertake the necessary planning, redesign, translation, training, and contract negotiations in order to implement CG-CAHPS (Clinician and Group Consumer Assessment of Healthcare Providers and Systems) in DY8	DHS is in the initial planning stages of implementing CG-CAHPS.
Care Coordination	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	DHS is refining the data collection methodology needed to track the numerator and denominator for Category III metrics. Two analysts were transferred from CHP to the Office of Planning in early September to focus on data collection, analysis, and reporting for Category III.
	Report the following: Numerator: All inpatient discharges from the DPH system of patients age 18 - 75 years with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
Preventive Health	Report the following: Numerator: All female patients age 50 - 74 years who had a mammogram to screen for breast cancer within 24 months Denominator: Number of female patients age 50 – 74 years who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 50 and older who received an influenza immunization during the flu season (September through February) Denominator: Number of patients age 50 and older who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
At Risk Populations	Report the following: Numerator: All patients age 18 - 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes mellitus who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	
	Report the following: Numerator: All patients age 18 - 75 years with diabetes whose most recent hemoglobin A1c level is in control (<9%) within the demonstration year reporting period Denominator: Number of patients age 18 – 75 years with diabetes who have visited the DPH system primary care clinic(s) two or more times in the past 12 months	

